(X6) DATE:

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PLAN OF CORRECTION (POC) IDENTIFIC		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	R: A. BLDG:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 06/05/2023			
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902			1425 PHILAD	STREET ADDRESS, CITY, STATE, ZIP CODE: 1425 PHILADELPHIA AVENUE CHAMBERSBURG, PA 17201					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	CTION (EACH OULD BE APPROPRIATE	(X5) COMPLETE DATE				
F 0000 F 0600 SS=G	Based on a complaint a completed on June 5, 2 Chambers Pointe Healt compliance with the fo CFR Part 483, Subpart Term Care Facilities at Commonwealth of Pen Licensure Regulations survey process.	023, it was determine the Care Center was rellowing Requirements for the 28 PA Code, insylvania Long Tenter for the Health portion	not in nts of 42 r Long m Care on of the	F 0600	TITLE	(X6) DATE-			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395944				06/05/2023	
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902		RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSI	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	(X5) COMPLETE DATE
F 0600	Continued from page 1		F 0600				
SS=G	\$483.12(a)(1) Free from Abu \$483.12 Freedom from Abu The resident has the right to misappropriation of residen defined in this subpart. Thi freedom from corporal puni and any physical or chemica the resident's medical symp \$483.12(a) The facility mus \$483.12(a)(1) Not use verba abuse, corporal punishment. This REQUIREMENT is no	ase, Neglect, and Exploit be free from abuse, neg t property, and exploitat s includes but is not lim shment, involuntary sec al restraint not required toms. t- al, mental, sexual, or phy , or involuntary seclusio	glect, ion as ited to lusion to treat		All nursing staff have the responsibility to implement care-planned interventions, physician orders and/or facil policies to keep residents fre abuse and neglect. This incl following a resident's transfe and the potential consequence both the team member and the resident when care-planned interventions and/or facility are not followed. Nurse Aid requested by Resident 2 to with prior to bed. According to a interview conducted by the Mome Administrator (NHA) Aide 1, reviewed Resident 2 plan prior to walking her which stated the resident required comember and a wheeled walk transfers and walking. Nurse followed the plan of care and the resident accordingly. When we will be to go back toward her received the resident 2 stated she felt diz Resident 2 has documented to of vertigo. Before Nurse Aida able to get Resident 2 safely	re from udes er status ees to ne policies ee 1 was valk her n Nursing , Nurse 's care ich one staff eer for ee Aide 1 d walked hen t 2 to com, tzy. history de 1 was	Completion Date: 06/30/2023 Status: APPROVED Date: 06/23/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395944			<u>vv</u>		
CHAMBE	OVIDER OR SUPPLIER: CRS POINTE HEALTH CAI SE NUMBER: 064902	RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSI	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOUTH		OULD BE	(X5) COMPLETE DATE
F 0600 SS=G	Continued from page 2			F 0600	wheelchair she was followin Resident 2 with, Resident 2 forward. The fall resulted in fractured nasal bone. The N called and immediately bega investigation, interviewing N Aide 1. Nurse Aide 1 stated reviewed the care plan prior walking Resident 2 but "then no gait belt in the room." W NHA asked Nurse Aide 1 where it is not a whold go find one." Later interview the NHA asked Nurse Aide 1 states should "go find one." Later interview the NHA asked Nurse Aide 1 what it means when a resident is not care-planned gait belt and she responded, use one. But I guess next tire everyone I will." Nurse Aid been educated about the use belts upon hire on 1/25/23 the through in-services on 2/1/2 2/14/23, and again on 3/3/23 NHA re-educated Nurse Aid the time of the incident/inter that the only residents who duse a gait belt for transfers/ware those that are care planned.	fell n a HA was n Nurse she to re was 'hen the hat she gait belt ated she in the urse a for a "Not to me with e 1 had of gait nen again 3, . The le 1 at view lo not valking	

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION: (X3) DATE SURVEY PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER: COMPLETED: A. BLDG: <u>00</u> B. WING: __ 06/05/2023 395944 NAME OF PROVIDER OR SUPPLIER: STREET ADDRESS, CITY, STATE, ZIP CODE: 1425 PHILADELPHIA AVENUE CHAMBERS POINTE HEALTH CARE CENTER CHAMBERSBURG, PA 17201 STATE LICENSE NUMBER: 064902 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY (X4) ID ID (X5)PROVIDER'S PLAN OF CORRECTION (EACH **PREFIX** MUST BE PRECEEDED BY FULL REGULATORY OR LSC PREFIX TAG CORRECTIVE ACTION SHOULD BE COMPLETE TAG IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE F 0600 Continued from page 3 F 0600 SS=Gnot have a gait belt; all other residents use gait belts. Additionally, all clinical team members were re-educated on the gait belt policy. Nurse Aide 1 was required to go through her new hire orientation, including the gait belt policy, and have it completed by 6/16/23. In order to ensure all team members use gait belts and this same type of incident does not occur again, gait belts were re-distributed to all resident rooms and all staff members. All Nurse Aides, Licensed Practical Nurses, Registered Nurses (whether staff members, agency or contracted) as well as therapists will be required to have a gait belt on-person while providing care for the residents. 10 random audits of all shifts will be conducted weekly for 12 weeks to ensure compliance with this regulation. In addition, staff will be educated through a directed in-service on the parameters of this regulation that will be conducted on 6/22/23 by an approved Directed Inservice provider. Knowing and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395944				06/05/2023	
CHAMBE	VIDER OR SUPPLIER: RS POINTE HEALTH CAI JE NUMBER: 064902	RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSE	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX TAG CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE AP		OULD BE	(X5) COMPLETE DATE
F 0600	Continued from page 4			F 0600			
SS=G					understanding what is care-p for each resident will also be to obtain compliance with th regulation and ensure future compliance is maintained. S members will be re-educated to access and where to locate resident care plans. 10 audit conducted randomly for 12 v individual care residents' car The DON or designee will d creative questioning, quizzin documentation of resident ca and ensure team members ar capable of responding accord that individual resident's care	e a focus is Staff I on how e all s will be weeks on e plans. evelop ag and are plans ee ding to	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395944				06/05/2023		
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902			STREET ADDRESS, 1425 PHILADI CHAMBERSB	ELPHIA A	VENUE			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0600	Continued from page 5		F 0600					
SS=G								
	Based on review of factoreports, clinical records, as well as staff determined that the factoresidents were free from residents reviewed (Renesident 2 due to a fall Findings include: The facility's policy regulated April 13, 2023, into provide protection for rights of each resident implementing written prohibit and prevent about and misappropriation of the Anadmission Minimum assessment (a mandate abilities and care needs March 30, 2023, reveals	s, and staff education of interviews, it was illity failed to ensure on neglect for one of sident 2), resulting it that resulted in fractional state of the health, welfare by developing and policies and procedures, neglect, exploit of resident property. In Data Set (MDS) dissessment of a resident 2, data of the sident 3, data o	e that seven In harm to etures. eglect, ility was e and res that tation,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
395944			A. BLDG: _ B. WING: _	00	06/05/2023		
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902		RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSE	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0600	Continued from page 6			F 0600			
SS=G	cognitively intact, required two staff for transfer with ambulation (walk and balance herself with recent falls. The resided 25, 2023, revealed that member and a wheeled A nursing note, dated A revealed that the nurse Resident 2 was found I stomach, and there was under her face, which we resident's nose. The brown was swollen with bruis was transferred to the I (diagnostic test), dated resident had a fracture. The facility's investigate revealed that Resident I walk with her, and N resident with her whee	rs, required limited a ing), was only able to the staff assistance, and ent's care plan, dated a she required one state walker for transfers. May 20, 2023, at 11: aide was yelling for ying on the ground of a large amount of the was coming from the ridge of the resident's sing and a laceration mospital. A CT-scan May 21, 2023, reve of the nasal bone.	o stabilize nd had no March off a. 09 p.m. help and on her blood as nose and she aled the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395944 A. BLDG:00 B. WING: 06/05/2023					
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902		RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSE	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0600	Continued from page 7		F 0600				
SS=G	with her rolling walker the resident to turn and resident said she was dould be seated, she fet a history of being dizzy three times a day. The Nurse Aide 1 was not ut the fall. Nurse Aide 1 resident did not need a planned. The facility's new emp January 25, 2023, reve completed training reg with a gait belt. An interview with Nur 2:47 p.m. confirmed the while walking and train was not care planned; I she received education belt.	l go back to her room izzy, and before the Il forward. The resid y and receives medic investigation detern using a gait belt at the stated that she thoug gait belt since it was loyee training check aled that Nurse Aide arding transfer/ambu	n the resident dent has eation nined that he time of the the sonot care list, dated a lalation 2023, at gait belt because it afirm that				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULT	(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395944			_00	06/05/2023		
CHAMBEI	VIDER OR SUPPLIER: RS POINTE HEALTH CAI SE NUMBER: 064902	RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSI	ELPHIA A	VENUE			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
F 0600	Continued from page 8			F 0600				
SS=G	An interview with the on June 5, 2023, at 2:2 Aide 1 did not use a ga ambulating Resident 2 neglect was substantiat 42 CFR 483.13 - Resider Practices, 10-1-1998 et 28 Pa. Code 211.10(c) 28 Pa. Code 211.11(d) 28 Pa. Code 211.12(d)	5 p.m. confirmed that belt when transfer and she should have ted. dent Behavior and Fadition. (d) Resident care points.	at Nurse rring and e, and that acility licies.					
F 0689				F 0689				
SS=G								

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PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED:		
		395944				06/05/2023	
CHAMBEI	VIDER OR SUPPLIER: RS POINTE HEALTH CAI E NUMBER: 064902	RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSI	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0689	Continued from page 9			F 0689			
SS=G	483.25(d)(1)(2) Free of Acc Hazards/Supervision/Device §483.25(d) Accidents. The facility must ensure tha §483.25(d)(1) The resident accident hazards as is possil §483.25(d)(2)Each resident and assistance devices to pr	t - environment remains as ble; and receives adequate super event accidents.			Nurse Aide 1 was requested Resident 2 to walk her prior According to an interview conducted by the Nursing He Administrator (NHA), Nurse reviewed Resident 2's care p to walking her which stated resident required one staff m and a wheeled walker for tra and walking. Nurse Aide 1 the plan of care and walked resident accordingly. When Aide 1 asked Resident 2 to trago back toward her room, Restated she felt dizzy. Reside documented history of vertig Before Nurse Aide 1 was ab Resident 2 safely to the when she was following Resident 2 Resident 2 fell forward. The resulted in a fractured nasal The NHA was called and immediately began investigatinterviewing Nurse Aide 1. Aide 1 stated she reviewed the plan prior to walking Reside "there was no gait belt in the When the NHA asked Nurse what she should do when the	to bed. ome e Aide 1, lan prior the ember insfers followed the Nurse urn to esident 2 int 2 has go. le to get elchair 2 with, e fall bone. tion, Nurse he care int 2 but room." Aide 1	Completion Date: 06/30/2023 Status: APPROVED Date: 06/21/2023

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	(XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION: (X3) DATE SURV (AN OF CORRECTION (POC) (DENTIFICATION NUMBER: A. BLDG: 00		(X3) DATE SURVE COMPLETED:	ΣΥ			
		395944		1		06/05/2023	
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902		RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSE	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 10			F 0689			
SS=G					a gait belt in the room Nurse stated she should "go find on Later in the interview the NF Nurse Aide 1 what it means resident is not care-planned figait belt and she responded, use one. But I guess next tin everyone I will." Nurse Aide been educated about the use belts upon hire on 1/25/23 th through in-services on 2/1/23 2/14/23, and again on 3/3/23 NHA re-educated Nurse Aid the time of the incident/interthat the only residents who duse a gait belt for transfers/ware those that are care plannen on thave a gait belt; all other residents use gait belts. Additionally, all clinical teammembers were re-educated of gait belt policy. Nurse Aide required to go through her neorientation, including the gait policy, and have it completed 6/16/23. In order to ensure a members use gait belts and the type of incident does not occur again, gait belts were re-distributed.	HA asked when a for a "Not to me with e 1 had of gait ten again 3, . The e 1 at view to not valking ed to men the 1 was ew hire it belt d by this same our	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395944		B. WING: _		06/05/2023	
CHAMBE	VIDER OR SUPPLIER: RS POINTE HEALTH CAI E NUMBER: 064902	RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSE	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE PREFIX TAG CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP		OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 11			F 0689			
SS=G					to all resident rooms and all members. All Nurse Aides, Practical Nurses, Registered (whether staff members, age contracted) as well as therap be required to have a gait be on-person while providing cathe residents. A directed in on the parameters of this reg will be conducted on 6/22/23 approved directed in-service provider, and 10 random and shifts will be conducted wee 12 weeks to ensure compliar this regulation. In addition, policy review and training w part of the new hire orientati process.	Licensed Nurses ency or eists will lt are for eservice gulation 3 by an edits of all ekly for ence with gait belt vill remain	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395944		B. WING: 06/05/2023		06/05/2023	
CHAMBE	IVIDER OR SUPPLIER: RS POINTE HEALTH CAN SE NUMBER: 064902	RE CENTER	STREET ADDRESS, 1425 PHILAD CHAMBERSI	ELPHIA A	VENUE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 12			F 0689			
SS=G	Based on review of factoreports, clinical records records, as well as staff determined that the factoring adequate assistant accidents for one of set (Resident 2), resulting fall and fracture. Findings include:	s, and staff education f interviews, it was ility failed to provid ace devices to prevent wen residents review	n le care nt red				
	The facility's policy read April 13, 2023, indicate used with residents that ambulate or transfer for nursing department embelt during orientation, education on the proper orientation and annually responsibility of each education that it available for use at a	re to be lently ety. Each ven a gait uld receive during					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395944		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 06/05/2023		
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902			STREET ADDRESS, CITY, STATE, ZIP CODE: 1425 PHILADELPHIA AVENUE CHAMBERSBURG, PA 17201					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	(X5) COMPLETE DATE			
F 0689 SS=G	An admission Minimum Data Set (MDS) assessment (a mandated assessment of a residabilities and care needs) for Resident 2, dated March 30, 2023, revealed that the resident was cognitively intact, required the extensive assist of two staff for transfers, required limited ass with ambulation (walking), was only able to and balance herself with staff assistance, and recent falls. The resident's care plan, dated M 25, 2023, revealed that she required one staff member and a wheeled walker for transfers. A nursing note, dated May 20, 2023, at 11:09 revealed that the nurse aide was yelling for he Resident 2 was found lying on the ground on stomach, and there was a large amount of blo under her face, which was coming from the resident's nose. The bridge of the resident's nose was swollen with bruising and a laceration, and was transferred to the hospital. A CT-scan (diagnostic test), dated May 21, 2023, revealed resident had a fracture of the nasal bone.		was ssistance ssistance o stabilize ad had no March aff s. 09 p.m. help and on her blood es nose and she	F 0689				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
395944			B. WING:		06/05/2023			
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902			STREET ADDRESS, CITY, STATE, ZIP CODE: 1425 PHILADELPHIA AVENUE CHAMBERSBURG, PA 17201					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	(X5) COMPLETE DATE			
F 0689	Continued from page 14		F 0689					
SS=G	The facility's investigation, dated May 20, 2023, revealed that Resident 2 requested that Nurse Aide 1 walk with her, and Nurse Aide 1 followed the resident with her wheelchair as the resident walked with her rolling walker. When Nurse Aide 1 asked the resident to turn and go back to her room the resident said she was dizzy, and before the resident could be seated, she fell forward. The resident has a history of being dizzy and received medication three times a day. The investigation determined the Nurse Aide 1 was not using a gait belt at the time the fall. Nurse Aide 1 stated that she thought the resident did not need a gait belt since it was not caplanned. The facility's new employee training checklist, dat January 25, 2023, revealed that Nurse Aide 1 completed training regarding transfer/ambulation with a gait belt. An interview with Nurse Aide 1 on June 5, 2023, a 2:47 p.m. confirmed that she did not use a gait belt while walking and transferring Resident 2 because		rse Aide d the t walked 1 asked n the resident dent has cation nined that he time of ght the s not care list, dated e 1 halation 2023, at gait belt					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIED IDENTIFICATION NUMBER 1995944			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 06/05/2023	ΞY	
NAME OF PROVIDER OR SUPPLIER: CHAMBERS POINTE HEALTH CARE CENTER STATE LICENSE NUMBER: 064902			STREET ADDRESS, CITY, STATE, ZIP CODE: 1425 PHILADELPHIA AVENUE CHAMBERSBURG, PA 17201				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
F 0689	Continued from page 15			F 0689			
SS=G	was not care planned.						
	An interview with the Nursing Home Administrator on June 5, 2023, at 2:25 p.m. confirmed that Nurse Aide 2 did not use a gait belt when transferring and ambulating Resident 2 and she should have.						
	28 Pa. Code 211.12(d)	(1)(5) Nursing servi	ces.				

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Certified End Page

CHAMBERS POINTE HEALTH CARE CENTER

STATE LICENSE NUMBER: 064902 SURVEY EXIT DATE: 06/05/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY